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A Newsletter for MassHealth Providers

Update

Web Site Enhancements

In December 2004, the Commonwealth's Executive Office of Health and Human Services (EOHHS) successfully migrated the MassHealth Provider Services Web site (www.mahealthweb.com) into the EOHHS Web portal. The portal presents a single point of contact for users, and provides a uniform look and consistent navigation. All information for MassHealth providers is now available from the MassHealth site at www.mass.gov/masshealth. Note: If you visit www.mahealthweb.com you will automatically be redirected to the EOHHS Web portal.

There are two ways to find MassHealth provider information on the EOHHS/MassHealth portal.

From www.mass.gov/masshealth, click on "Information for MassHealth Providers." This will take you to a list of topics similar to the previous Web site.

You can also find information by clicking on the "Provider" tab at the top of the screen. This will take you to a page with the following categories. (Note: This page includes information about other EOHHS agencies.)

- Enrollment and Contracting
- Certification and Licensure
- Invoice and Claims Submission
- Guidelines for Services & Planning
- Guidelines for Clinical Treatment
- Provider Information Maintenance
- Reporting to the State
- Resources and Guidance

For additional information, see All Provider Bulletin 140 (November 2004), or call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

Secure File Delivery Is Here

MassHealth has launched Phase I of a secure file delivery application (SFDA) for non-retail pharmacy transactions. This new Web application is our recommended method for receiving HIPAA-compliant files instead of compact disks or the bulletin board system. Phase I allows our trading partners to receive the following HIPAA-compliant transactions via the Internet: 820, 834, 835, and 997. Providers currently receiving either the 835 or 997 transaction received an e-mail (if an e-mail address is on file) containing a registration form.

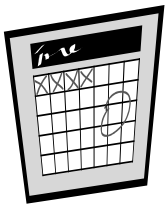
Providers who currently receive the proprietary supplemental electronic remittance advice will be able to retrieve that information via the SFDA as well.

The SFDA works like an e-mail application. It provides a fast and secure way for you to receive, via the Internet, links to the applicable file downloads, and attachments. If you contract with a billing intermediary to receive any of these transactions, be sure to ask the intermediary about this new option.

Phase II of the rollout of the SFDA application will allow trading partners to submit the HIPAA-compliant 837 transaction file to MassHealth via this method. You will receive more information about Phase II in the coming months.

For additional information, see All Provider Bulletin 139 (November 2004), or contact the MassHealth HIPAA Support Center at mahipaasupport@unisys.com or 1-888-848-5068.

Prior Authorization for Therapy Services



Effective January 1, 2005, MassHealth has increased the number of payable therapy visits before PA is required.

Effective January 1, 2005, MassHealth will increase the number of visits for therapy services within a rolling 12-month period before prior authorization (PA) is required. The new numbers of payable visits are:

- 20 visits for physical therapy (PT);
- 20 visits for occupational therapy (OT); and
- 35 visits for speech and language therapy (ST).

We encourage providers to submit requests for PA through our Web-based Automated Prior Authorization System (APAS) at www.masshealth-apas.com. To receive more information about requesting PA using APAS, including training for access to APAS, call 1-866-378-3789.

We recently issued provider bulletins with details of this revised policy. To view the bulletins, please visit www.mass.gov/masshealthpubs and click on "Provider Library." If you have questions about this policy, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

MassHealth strongly encourages providers to submit requests for prior authorization using APAS.

Prior Authorizations Submitted by Therapy Group Practices

Group practices requesting prior authorization (PA) for therapy services must submit their request under the *individual* independent therapist's servicing provider number, not the group practice provider number. If you have requested a PA using the Automated Prior Authorization System (APAS), and received PA under your group practice provider number (the number beginning with 97) on or after April 15, 2004, claims for these services may have been denied with error 159 (the provider number on the claim does not match the provider number on the PA).

When submitting PA requests via the Internet, you must contact the APAS administrator, Ancillary Care Management (ACM), at 1-866-378-3789 to provide a list of all independent servicing therapists in your group.

When submitting PA requests on paper, enter the independent therapist's provider number in Item no. 3 of the Prior Authorization Request form.

For additional information, including instructions for correcting PA submitted under the group provider number, see Therapist Bulletin 12 (December 2004).

A prior-authorization request must be submitted under the individual practitioner's MassHealth provider number.

Home Health Agencies Must Seek Coverage Determination

When a MassHealth member has commercial insurance in addition to MassHealth, home health agency (HHA) providers must seek a coverage determination from the commercial insurer any time a member has a qualifying event. Some of the qualifying events described in Transmittal Letter HHA-33 (June 2002) are:

- a new admission or re-admission to an HHA;
- discharge from an acute or skilled facility;
- cessation of commercial insurance coverage or exhaustion of annual or other periodic benefit(s);
- reinstatement of insurance benefits on an annual basis; or
- a change in the member's medical condition resulting in a change in the plan of care.

Fax or mail the third-party coverage determination to MassHealth within 10 days of its receipt.

When a qualifying event occurs, you must seek the third-party coverage determination, submit a copy of it to MassHealth within 10 days of its receipt, and keep a copy for your own records. Include the following information when sending insurance determinations to MassHealth: the member's name, MassHealth identification number or date of birth, the dates of service, the type of service, and your MassHealth provider number. Please fax or mail this information to:

Fax: 617-210-5080
MassHealth
Benefit Coordination and Recovery
Home Health Claims
600 Washington Street
Boston, MA 02111.

Providers may continue to bill MassHealth if there is no qualifying event, or if the member continues to receive services after the initial third-party insurance determination is obtained.

If submitting these claims electronically using the HIPAA-compliant 837I transaction, fill in the other payer loops (2320 and 2330) with the correct condition code from Home Health Agency Bulletin 41 (November 2003). If submitting these claims on paper, you must use the commercial insurance patient status codes as outlined in Transmittal Letter HHA-33 (June 2002). You may continue to bill directly to MassHealth if there is no qualifying event, or if the member continues to receive services after you have obtained the initial third-party insurance determination. The use of patient status/condition codes verifies that you have obtained a valid third-party insurance determination, and explains why the third-party insurer is not covering the service(s). You may only bill using the patient status or condition codes if a valid third-party insurance determination is on file with MassHealth.

The use of patient status/condition codes verifies that the provider has obtained a valid third-party insurance determination, and explains why the third-party insurer is not covering the service(s).

Please note that there have been no changes in the home health *Medicare* billing. You must follow the billing instructions for both commercial insurance and Medicare for members who are eligible for both. You would then use the corresponding commercial insurance patient status code for paper billing.

MassHealth Reminders

Global Payment for Physicians
MassHealth has eliminated global billing for services with a professional and technical component as stated in Transmittal Letters PHY-98 and PHY-100 (January 2004 and May 2004). Effective for dates of service beginning February 1, 2004, physicians, nurse practitioners, and nurse midwives furnishing both the professional and technical components of a service must bill for these components separately to receive the equivalent of the global payment. To submit a claim for the professional component, providers must append modifier 26 to the appropriate service code. To submit a claim for the technical component, the provider must report the same service code on a second claim line and append modifier TC.

For claims with dates of service on or after February 1, 2004, services that have professional and technical components must be billed with a modifier, using two claim lines if both components were performed. Claims for such services that are not billed with modifier 26 or TC will be denied with error 135 (modifier required). This denial will be reflected with an adjust reason code 04 and remarks M78 on the HIPAA-compliant 835 Health Care Claim Payment /Advice transaction. Claims cannot be billed with modifier 99 (multiple modifiers); they must be billed separately on two claims lines with modifiers 26 and TC as described above. Claims billed with modifier 99 will deny with error 063 (the modifier is incorrect for the service billed). This will be reflected with an adjust reason code B18 and remarks M78 on the 835 transaction.

HIV Resistance Testing
Claims with dates of service on or after September 10, 2004, for HIV resistance testing with Service Codes 87901, 87903, and 87904, no longer require prior authorization. However, providers are reminded that MassHealth pays for these services only when provided by independent clinical laboratories that have the appropriate certification from the Centers for Medicare and Medicaid Services under the Clinical Laboratory Improvement Act (CLIA). If you have any questions about this information, contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

Bed Hold Days for Certain Dually Eligible Members
Claims for bed hold days for dually eligible MassHealth members (members having another primary insurance) not yet coded to your facility, and who are on a leave of absence during the course of their Medicare or other insurer's active benefit period, must be sent along with a cover letter to: MassHealth, Attention: Meg Crowley, 600 Washington Street, Boston, MA 02111.

This change is effective for all claims meeting the above criteria with dates of service on and after July 1, 2004.

Management Minutes Questionnaire
When completing the Management Minutes Questionnaire (MMQ) for members who were discharged from a nursing facility and later readmitted, the effective date of the MMQ change must coincide with the appropriate admission date. For instance, if the patient is discharged August 31, 2004, and readmitted October 1, 2004, and the effective date for the change on the MMQ is October 15, 2004, the admission date should be entered as October 1, 2004.

If you have any questions about this information, please contact the MassHealth Casemix Unit at 617-210-5300.

MassHealth Contact Information
HIPAA Support Center
E-mail: mahipaasupport@unisys.com
Telephone: 1-888-848-5068
Provider Enrollment and Credentialing
Fax: 703-917-4931
Telephone: 617-576-4424 or 1-800-322-2909
Provider Services
Fax: 617-576-4487
Telephone: 617-628-4141 or 1-800-325-5231
Web site
www.mass.gov/masshealth